MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
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10:20 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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MARY K. WAKEFIELD, Ph.D.
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AGENDA ITEM:

Workplan for inpatient and outpatient hospital payment issues -- Jack Ashby, Julian Pettengill, Chantal Worzala, David Glass

DR. WORZALA: Good afternoon. We have a few logistics to straighten out here. We do have three different presentations in this session. I'm going to be presenting our workplan for hospital outpatient issues first. That's a little bit of a change of the usual order. After that, Jack and Julian will go through the inpatient workplan and I will depart stage left and David will come in and do some information on labor markets.

So my own presentation on the hospital outpatient workplan has three parts. First, just providing some background information that will provide context to our update discussion. Then I'll discuss the analyses we propose to conduct as part of our payment adequacy assessment. Finally, I will briefly mention a couple additional outpatient analyses that we already discussed in some detail at the retreat.

As context to the update discussion I wanted to bring you new information on outpatient spending, and also the services that Medicare pays for in the outpatient department. Outpatient spending is increasing rapidly, as you may have noticed in Anne's presentation this morning. The Office of the Actuary revised their estimate of total spending -- that's program plus bene -- in 2001 for all OPD services from an estimate of $18.4 billion which we used in our March report, to $20.4 billion. So that's a pretty significant revision upward. Part of the reason for the revision was a technical issue of how they assigned payments to different sectors under Part B, but a lot of stems from both increased and increased payment rates. So that was something like a 17 percent growth in one year on hospital outpatient payments.

Of the $20,4 billion, an estimated $18.4 billion was spent on services covered by the outpatient PPS. These increases do mark a rapid resurgence in outpatient spending which grew rapidly in the '80s and early '90s, had moderated in the mid to late '90s and is now picking up again. We do have projections of continued growth in the future.

The second piece of background information is just showing you what services Medicare purchases under the outpatient PPS because I think it's still a little bit of a mystery. The payment system covers a remarkable array of services, including surgeries, diagnostic tests, clinic and emergency visits, drugs, and immunizations, among other things.

So this chart shows the services that were paid for in 2001. It's based on our analysis of 100 percent claims file. Here we're including both program spending and bene cost-sharing, but none of the transitional corridor payments are included in the total here. The services were grouped into evaluation and management, procedures, imaging and tests based on the type of service indicators that CMS has developed and maintained. Then

the other things, the pass-throughs, drugs and devices, and the separately-paid drugs are based on their payment status under the payment system.

To give you an idea of what's in those groups, procedures includes ambulatory surgeries, cardiovascular procedures, eye procedures, radiation therapy, the git stuff. Then imaging includes advanced imaging, the MRIs and the CATs, acography and standard imaging. The tests would include EKGs, stress tests and the more intuitive lab tests that you would think fall under there.

So procedures did account for the largest share of spending, about 42 percent, followed by imaging at 29 percent, and evaluation and management. We don't have any trend data right now for how these are changing over time, but we can do 2001-2002 since we'll have 2002 data in fairly soon. Just a quick note, in 2001 the pass-through items accounted for about 8 percent of total spending and that's because the cap was not enforced in that year, so that number should shrink in 2002.

To get a little bit more specific, there is a diverse range of services provided and paid for in the outpatient department, but the payments are fairly concentrated on a smaller number of services. The APC that accounts for the greatest share of payments are advanced CT scans at 8 percent. Then if you put the emergency and clinic visits together, that's about a 10 percent of total payments. There's a fuller version of this table in your briefing materials and for the public in our data book.

That's just some background information. Looking now at our workplan for the coming year on assessing payment adequacy, we do plan to conduct much of our payment adequacy assessment for the hospital as a whole. This is both recognition of the fact that although Medicare pays silo by silo, the hospital is really providing these services across the board. It's also a recognition of the limitations of our cost report data.

So when we look at the current costs and payments and calculate our margins, we will look at the services provided by the hospital, our overall Medicare margin that includes inpatient, outpatient, SNF, home health, and the inpatient PPS-exempt services. Of course, that overall Medicare margin does tend to be the core measure when looking at payment adequacy. We will also generate, however, separate outpatient margins and when we do that we will recognize all the cost allocation issues that complicate the interpretation by service line.

Just a quick preview. When we do our 2001 and hopefully 2002 cost report analyses, these will be the first cost reports that include time periods of full OPPS implementation. So this will be our first check on how hospitals are faring under the OPPS. Then when we look at access to capital, that too will be for the hospital as a whole. I'm not sure that hospitals raise capital separately for one department versus another, so that's a broader context.

Then we look at entry and exit, that's something that we will do both for hospitals as a whole. Are hospitals closing faster in one place than another? What's the trend in capacity? But we'll also look a little bit at outpatient services

specifically. I did include a table about this in your briefing papers looking at the provider of services file. That does show that the share of hospitals providing outpatient services are increasing slight, looking at the provider of services file from '91 to 2001 showed a small increase from 92 to 94 percent of hospitals that provide any outpatient services. Again, a very slight increase, I believe, in the percent providing emergency services which was 93 percent in 2001. But outpatient surgery is becoming more common across the hospitals, from 79 to 84 percent of hospitals providing outpatient surgery.

Then the next facet of our payment adequacy discussion looking at quality of care, we're hoping to do a more extensive analysis this year than in previous years, and Karen discussed this morning some of the data sources that we're going to be looking at that and some of the indicators that we might have at our disposal. Unfortunately, it seems that inpatient services will be much more easy to measure than outpatient services but I'll keep pushing in that direction and see how much we can use ambulatory care measures that have been developed more generically and apply them to the outpatient setting.

In the context of payment adequacy what we'll want to be doing is building a time series for these things to look at, changes in quality over time as well as the actual level.

Finally on access to care, I hope to do a little bit of analysis of changes in volume of certain services from 2001, picking out services where observers and stakeholders have expressed a concern over payment rates that are too low. Here we might look at emergency and clinic visits or services that had large payment declines from 2001 and 2002. If you have any suggestions for that list, please do let me know. A caveat to that whole analysis is that finding a decrease in the volume of the service does not necessarily indicate an access problem, because you may have changes in practice, and you may have services moving to a different setting out of the hospital to another ambulatory care setting. But I think it would be indicative of where we might want to look more closely.

Finally, three more items that we are going to be doing over the next year. First, an analysis of the outpatient PPS outlier policy. The kinds of policy questions we're looking at it is, first, is the outlier policy needed? This is the only ambulatory care setting that has an outlier policy. Second, if it is needed, should it be restricted to a smaller number of services.

The kinds of analyses we'll be looking at is the distribution of outlier payments among types of services and also among hospitals and groups of hospitals.

The second item here is a study of hospitals' cost allocation and charge setting purchases. The reason that speaks to the outpatient department is that we use hospitals' charges reduced to cost to set the payment rates. So the question is whether or not these practices are affecting the actual payment rates for services. Jack will describe that study in much more detail.

Finally, is hopefully an attempt to look more closely at the hold harmless payments for small rural hospitals, which absent

legislation will expire this year. But I should say, our ability to do this analysis is really dependent on data and I'm working on it.

So with that I'll turn it over to these guys unless, Glenn, you want to take questions now or just at the end.

MR. HACKBARTH: Why don't we go through the whole thing if that's okay with you, Chantal.

MR. PETTENGILL: I'm going to begin, as Chantal did, with some brief background context information about the inpatient setting and Medicare's inpatient payment system and spending thereon. Then I'll talk about the specialty hospital analysis, or specialty provider analysis that we're just starting. Then Jack will follow with the cost allocation study and some discussion of our analyses related to payments for indirect cost of medical education, direct cost of graduate medical education, and payments for treating a disproportionate share of low income patients; sort of the three horsemen of the acronyms or something. Then David will come back and talk about core-based statistical areas.

On the spending, as Anne pointed out this morning, payments for hospital inpatient care account for about 40 percent of Medicare spending. Most of that is in hospitals paid under the hospital inpatient acute care PPS. For most of those providers, Medicare spending averages somewhere between 30 and 40 percent of their total revenues for all services. Spending under the hospital inpatient PPS grew at a little over 9 percent per year over the last three years from 2002 to 2003, so it's now up to almost $100 billion. For what it's worth, CBO projects that it will grow at 6.2 percent per year over the next ten years.

Although the number of acute care general hospitals that are eligible for PPS has been fairly steady at about 4,900, an increasing number of small rural hospitals have been switching to critical access hospital status, thereby removing themselves from the inpatient PPS. We've gone from about 200 in the summer of 2000 to 806 now, which is brief rapid growth.

Now I'm going to turn to the agenda for the specialty hospital or specialty provider analysis. I keep saying hospital but I don't mean that. Much concern has been expressed recently among community general hospitals about the growth of specialty hospitals that focus on narrow classes of patients such as cardiac procedures, orthopedics, oncology, or general surgery.

The main allegations are two. First, that specialty providers take the most profitable kinds of patients, leaving general hospitals with reduced ability to fund important activities such as providing uncompensated care or maintaining standby capacity, or one of several others. The second allegation is that physician owners can self-refer and thereby select the least complicated patients, again leaving community general hospitals with an unfavorable selection and lower margins. Now these are allegations, not facts.

But I want to point out that specialization is not new. It's not limited to specialty hospitals providing inpatient or outpatient care. It's been common in ambulatory and post-acute care for many years, and even to some extent in inpatient care.

In addition that's shown on the next slide, many motivations may be at work here. So we want to address the potential origins and impact of this phenomenon as broadly as we can.

This slide, I want to spend a moment on the motivations for forming specialty providers because, as the mailing suggested, we have a number of studies here and each of them is attempting to get at one or more of the motivations for doing this. There are two broad groups of motivations here. Some represent potential attractions that might cause physicians and others to want to form specialty providers, and the other group are motivations that may be more a matter of trying to get away from unattractive features of more traditional settings.

In the first group we have, for example, the possibility that some procedures are very favorably priced by Medicare and/or private payers. For example, profitable DRGS. Specialty entities might enter the market in order to take advantage of that and take the money off the table, so the speak.

Another advantage they may have is that production can be tuned to a limited set of procedures where you can buy the right kind of equipment and hire the right kind of staff and train them to do this limited menu of care, and they can become very efficient at it. In addition, physicians may well have much greater control over the workflow in this kind of environment, thereby increasing their throughput. They may also have many fewer interruptions. If you don't provide emergency care, no one's going to kick you out of the operating room because they need it, so they can perhaps operate on a tighter schedule and maximize their output, thereby increasing their income.

In addition, they may be able to select only patients that are clinically appropriate for a routinized care system, which is also likely to add to profitability. Some of them may be attracted by the opportunity to be an entrepreneur with an ownership stake in the facility, earning not only the physician fees but, in addition, a share of the profits from the operation of the hospital or other specialty provider.

On the other side, physicians may find it attractive because they feel like their incomes have been under pressure. Many physicians report that their incomes have been declining and this is another opportunity to add to their income. They may be also trying to avoid unattractive features of practicing in a general hospital environment in which they have on-call obligations and they have to travel back and forth among settings to treat patients and so on. All of these represent costs to them.

With those motivations in mind we outlined a number of studies in the mailing that we plan to undertake this year beginning with some descriptive work on what kinds of specialty providers are out there, where they're concentrated geographically, how fast have they been growing over time, what are the characteristics of the market they tend to enter, what are the principal services they furnish to beneficiaries, and how do those services compare with the services furnished by general providers in the same market?

Then we will, in addition, do a second study that focuses on the profitability of individuals -- in the DRGs which specialty

hospitals concentrate in. We'll use for that charges from the Medicare claims adjusted by cost to charge ratios from hospitals' cost reports, and then compare the resulting costs with Medicare's payment rates.

We will use the same data, the same Medicare claims data to also look at the issue of the extent to which is specialty providers may be selecting a favorable group of patients, that is lesser severity patients for the same DRGs. A recent study by the GAO found some evidence that they do.

A third analysis will focus on the question of what happens to volume of procedures in markets in which you have fairly high penetration by specialty providers? We're going to use ambulatory surgical centers as the test case for this. Specialty hospitals in cardiology and orthopedics and general surgery and so forth haven't been around long enough to have much data -- either much market penetration or much data on volume to be able to look at so we're going to look at the ASC market instead and try to see what happens there.

We may be able to actually take that a further step later, adding in information about other specialty providers in the same markets and specialty hospitals in the same markets to look at the potential impact that market penetration has on the financial performance of the general hospitals located in those markets. But the question there will be whether we have enough penetration to actually get anything, see and observe an effect.

In addition to that we're going to make some attempt to look at whether the payments for physician services are also to some extent contributing incentives, financial incentives for physicians to concentrate on specific procedures, looking at both the relative value units in the physician fee schedule and also at evidence from studies on returns to specialization in cardiology, for example.

We're also planning to devote some effort to identify useful quality measures. We have up there the question of whether specialty providers have any effect, as they claim, on efficiency and quality of care. It's very hard to talk about efficiency if you can't control for differences in quality. So the quality part of it's very important. I don't know how much we'll be able to accomplish there but we're going to make the effort.

As I said, we'll also try to look at pulling all these studies together. We'll try to get to the question, if we can, of what impact specialty providers have on the community general hospitals, and whether in fact they're suffering adversely from specialty providers taking away their bread-and-butter.

Now I'll turn it over to Jack.

MR. ASHBY: At this point we are turning to our study of hospital cost allocation and charge-setting practices. The first bullet here presents the general policy question, and that is, how do hospital charge-setting practices affect that our measurements of profitability? Then more specifically, how accurately can we measure margins by DRG or APC using Medicare data given the influence of charges on those measurements?

Then essentially the same question by service line, particularly inpatient and outpatient, but also hospital-based

home health and SNF, psyche and rehab units. As we've said many times in the past, we tend to think our inpatient margins are biased upwards and our outpatient margins, in fact all other margins, are probably biased downwards. We'd like to find out through this project how much difference that makes.

DR. MILLER: Jack, can you just for them -- in addition to the broader question, there's a direct linkage to specialty analysis that we were just talking about on the profitability of the DRGs. I just want to make sure that that's apparent to everybody. So this links up to a couple of different of things.

MR. ASHBY: Right. We'll get to that a little bit more in the next slide.

First, a little bit of explanation though, how charges do affect margins. If hospitals mark up service units used in one DRG, or for that matter, a set of DRGs like a service, if they mark up units in one DRG more than others, that actually has two different effects. One is that it tends to raise the DRG payment rate for that DRG because the relative weights for the DRG rates are based on charges. But it also results in overstating the cost assigned to that DRG when we use Medicare data because our allocation of costs are also, at least in part, based on charges.

But because hospitals' real cost for the DRG are not affected, Medicare data will tend to understate profitability for that DRG. Then since it's a zero sum game, there will be corresponding overstatements for other DRGs.

We fear that this phenomenon that we've described here will mean that the analysis of profitability for the services that specialty hospitals provide, as Julian described, won't be able to give us an accurate picture of profitability. So we think that this study will be quite important in providing information with which to evaluate the accuracy of our profitability measures by DRG or by service using Medicare data in Julian's project.

In this study --

MS. DePARLE: Jack, just quickly. You said that you were concerned that it wouldn't reflect the profitability of specialty hospitals. But don't you really mean that because of the way this data is constructed and because of the way hospitals do their charges, it may not accurately reflect the profitability of any hospitals, not just specialty?

MR. ASHBY: [off microphone] That's absolutely correct. But it ties into the sense of DRGs. That's absolutely right.

In this study we will select a sample of hospitals that have sophisticated cost accounting systems and that means, among other things, that they make minimum use of charges in their system for allocating cost. Then we will compare the allocation of cost for that set of hospitals by DRG, APC, and also by type of service using our Medicare data on the one hand and using the hospitals' own data on the other. We expect that the sample hospitals will in fact have accurate data because through prescreening we will have ensured that they possess the necessary tools, but also because we can basically assume that they want to have the most accurate estimates possible to support for own decision-making. So they have every incentive to do it right.

The second part of the project will be a survey of hospital

charge-setting practices. This will provide us with direct information on charge-setting through a series of telephone interviews. Among other issues, we will be addressing the actual process that the hospitals use to set charges, external factors that they may take into account like negotiations with players or like new competitors that have come on the scene, such as the specialty hospitals we've been talking about, and whether there are any systemic differences in markups of charges over costs that they intend to place into the system. For example, a higher markup on low-cost items versus high-cost items.

The survey will be conducted concurrently with the cost allocation study and it will include the hospitals that are in the cost allocation study, but we also broaden the sample in an attempt to be as representative as possible.

Turning to other issues, first the combination of IME, GME, and DSH payments. We will examine the distribution of all three of these sets of payments. Then we will analyze the relationship first between the IME adjustment, or more specifically, the ratio of residents to beds and Medicare costs. That's our analysis of the empirical level that we have done several times in the past. But then along a similar line, we will measure the relationship between the DSH adjustment as represented by each hospitals' low income share, and the same Medicare costs per discharge. Then we will also examine the relationship between DSH payments and uncompensated care.

In the area of labor markets and wage index, the key issue here we expect to be analyzing the implications of OMB's new MSA definitions. Because that is a new issue, David will be on in a moment to give you more information about it.

Lastly, we have the issue of our annual assessment of payment adequacy which leads to an update recommendation. Here I'm not sure that there's anything additional that really need be said, given Chantal's remarks. The only change in our process from last year is going to be an increased emphasis on developing quality measures, again, as Chantal has already covered.

MR. GLASS: Good afternoon. This is more of a heads-up to alert the commissioners that OMB has issued new definitions for geographic regions resulting from the 2000 census, and we wanted to bring up some of the issues that might be raised if the new definitions were incorporated into some of our payment systems.

The hospital wage index is used to adjust payments to hospitals to account for differences in input prices, and also it's used in other sectors as well. The wage index is computed now for each metropolitan statistical area, and one index is computed for the remaining counties in each state, those that are outside of metropolitan statistical areas. Those are combined into what's called a statewide rural area.

The new OMB definitions have changed several things. First, let me say that all the statistical areas talked about are counties or collections of counties. The composition of some of the metropolitan statistical areas have changed and that's a result of the new census numbers. Some areas have gained or lost lost population, commuting relationships have changed. To be an MSA, they must have an urban area of over 50,000, and outlying

counties are included that have significant economic relations, and that's measured by commuting patterns. So there will be 362 of these metropolitan statistical areas in the U.S. and 49 of those will be new.

Of interest to us are the new geographic areas that have been defined. These are the micropolitan statistical areas. These have an urban area of 10,000 to 50,000 people, and again adjacent territory with commuting relationship. There's going to be 560 of them. All other counties are outside these two so-called core-based statistical areas, and they're cleverly referred to as non-core based statistical areas. These county-based definitions also now hold for New England which previously had New England city and town areas. Those things are also kept around, but the idea is that all the country will now use -- can be now described in terms of these core-based statistical areas.

So we can see how things have changed. It is a bizarre kind of thing but we'll show you why we think it may have some importance. Basically what happens is, there used to be just -- the old classification was you either had MSAs or you weren't in an MSA. You were either in a metropolitan statistical or not. Now you have three choices. You can be in a metropolitan, a micropolitan, or a non-core based statistical area. So most of the counties that used to be in MSAs are still in MSAs, 805 of them. But the micropolitan areas, 44 of the counties that used to be in MSAs are now in micropolitan and six are now in the non-core based statistical areas.

But on the other hand, 285 of the non-MSA counties under the old classification are now included under the metropolitan area, and the rest is as shown. The point is, there's going to be 674 counties included in micropolitan areas and the number of counties that are outside of these areas used to be 2,286 and now it's down to 1,377. So these micropolitan areas bring in a large number of counties and take them out of what some people used to refer to as rural, but that's really not a correct definition -- the non-MSA areas.

So what this has done is encompassed more counties in the core-based areas and more of the population; 93 percent of the total population is now going to be in a core-based statistical area. OMB apparently was striving to get more of the nation's population and area into these core-based areas for purposes of describing what's going on in the country.

Now we're looking at the hospital wage index and we want to see how this relates to hospitals. This is the same kind of chart but now we're talking about number of hospitals in these classifications. Again, we're looking at the PPS hospitals, which is not including the critical access hospitals which I think Jack just mentioned, there's a lot of those now. It's over 800. So these are just the PPS hospitals.

Again, you're seeing the same pattern. There are a large number of hospitals that used to be in MSAs and still are, 2,462. But there are also going to be a total of 749 hospitals in these micropolitan areas.

Now the issues that we think this raises are two. When you try to incorporate the new micropolitan classification into the

existing wage index system, depending on how you do it, you're going to run into a number of issues no matter how you do it. If you do it one way similar to how -- if you treat micropolitan areas analogously to how you treat metropolitan statistical areas, you calculate a different wage index for each one of them. Then you run into the problem of you're going to a very small number of hospitals in some of these areas. For the micropolitan areas, over 90 percent of them will only have one or two hospitals in them.

In calculating a wage index based on wages in one or two hospitals raises a lot of issues. It may be unstable or reflect some peculiar circumstances rather than really the underlying wages in the area.

Actually, it turns out that some of the metropolitan statistical areas have the same issue. Under the new definitions, about 14 percent will have only one PPS hospital and another 20 percent have only two. Under the old definitions about 10 percent had one and 19 percent had two. So we need to think about how many hospitals are enough to come up with an approximation of prevailing input prices.

Now the other hand, if you don't treat them like metropolitan statistical areas but rather put them into what used to be called statewide rural areas, you raise the problem of you're putting all the micropolitan hospitals into these big wage index areas. But over half the hospitals in the micropolitan areas were either in MSAs before or were reclassified into MSAs for payment purposes. So a lot of those hospitals will probably object to being included in a new statewide rural area and will ask to be reclassified, so it will increase the problem probably of reclassification.

What that's basically saying is that it's a reflection of the issue that these very large areas that contain a lot of counties also contain a lot of smaller labor market areas, and they could have very different underlying wage levels. That's what we're trying to do is approximate the input wages.

So as next steps, if the Commission is interested in these issues, over the short-term we could further investigate some of the issues raised by the new definitions. For example, we could see what happens if we include critical access hospitals in the analysis.

Over the longer term we might want to develop criteria to evaluate some other labor market options and investigate some of those options and available data sources, because there may be other ways of coming up with what we think the input prices are. The idea is, how can you define the labor markets while not creating the boundary problems in the current system, and minimizing the administrative burden on hospitals and CMS, and possibly opportunities for gaming the system.

DR. MILLER: David, just one thing here. There's nothing that happens immediately on this. These definitions have just come out. CMS will start to do thinking and commenting on this. This is not like tomorrow all the systems are going to --

MR. GLASS: No. The idea was, in the event that CMS does decide to incorporate these definitions we want to be able to

react at that time.

DR. REISCHAUER: But even if it doesn't, the 174 hospitals that were in non-metropolitan that are now in metropolitan automatically would be in the metropolitan for the wage index, so they're better off no matter what.

MR. GLASS: They would be better off.

MR. SMITH: Chances are, Bob, a number of those have been reclassified.

DR. REISCHAUER: Have been reclassified already.

MR. GLASS: That's probably right.

DR. NEWHOUSE: I have some comments on both the profitability analysis and the wage index issues. On profitability, the cost side is conceptually difficult. There's two different kinds of decisions. One is, do I enter this market at all with this facility, say an ambulatory surgery center? For that, we have a couple problems. One is, I need to know what I'm going to make over my whole book of business, not just my Medicare book of business.

Secondly, I don't observe what people who didn't enter the market thought their costs were. Maybe they thought they weren't going to make money; their costs were higher.

The third thing is the usual issue about cost allocation practices. If I enter the market, while I may allocate a share of my CEO and CFO salary there based on revenues, but since I have a CEO and a CFO on board, how much more time they really spend because I added this ASC may not bear that much relationship to that. So the entry decision is one thing.

Then the second issue is, given that I've entered, what scale am I trying to run this at? That obviously is a marginal cost question. Then that brings up the question of whether the cost allocation is really relevant at all. Aren't I allocating mostly fixed costs? So there's definitely some traps in trying to do this analysis.

On the wage index, first of all I think it's a really interesting set of questions, but in principle I think you have consider what is the actual labor market? We know in the end we can't draw it exactly, but in in principle there is some kind of actual labor market out there, that is geographically-defined labor market. So if we have what we think approximates a labor market and there's only one or two hospitals in it, maybe we just have to use non-hospital wages for this purpose and forget about trying to get hospital-specific wages. And if there's some categories that are only employed in hospitals, we're just going to say that they just relate to everybody else's measures. I don't really see a very good answer other than that.

You asked, David, how many hospitals we would need statistically to get a good estimate. But I think at least as important an issue would be, how many do we need to minimize behavioral effects, from turning this into cost reimbursement? Another way to phrase that is, if it there's some threshold below which we're just not even going to consider hospitals wages, where is that threshold? I would have thought we would want to do it on some -- this is now off the top of my head so I want to think about this some more, but what was the largest hospital's

market share in whatever thing we were saying approximated the labor market?

So for example, if the largest hospital had more than a 25 percent market share, we would not then consider hospital-specific wages, or be more than 50 percent. I mean, somebody would have to pick a number. But that would be one way to go about this.

MS. DePARLE: My comment follows directly on Joe's. When I was out in Iowa, on the subject of geographic variation, I had a conversation with some very helpful people from, I think it was the Mercy Medical System. Do you remember, David, we talked about this? They made some very interesting points about intermediaries' collection of data, and the accuracy of that, and how much they check it, which if continue on the system it seems to me that's something we need to look at.

But there other point was, why are you using this hospital-specific data? Why not just use something that's already out there like BLS data on a geographic area that's more, they argued, objective; doesn't deal just with healthcare, so that we don't have these arguments all the time about the accuracy of data and all the various appeals to be in different areas, et cetera. It's something David and I have chatted about and I would hope that would be something you would look at. I think it's in the spirit of what Joe's suggesting. Is there some way to get out of this --

MR. GLASS: If it's of interest to the Commission we can pursue this, because the census is now changing the way they collect some of their data. They'll do it continuously rather than once every ten years.

DR. NEWHOUSE: The only problem I see is, although this is a problem no matter what you do, is what is the labor market? Within the New York City MSA there may be many sub-labor markets, and here we are stuck with the New York City MSA pluss all the hospitals that have been reclassified into it.

MR. SMITH: It's also complicated by how much of the hospital's staff is actually competing in that labor market, however you define it. It may well be that the folks in Des Moines on the medical staff are more appropriately thought about in terms of being in the Chicago labor market, whereas the rest of the staff isn't. So it gets back to the questions that we've talked about before about how do we would look at -- how do we adjust for the mix of locally-employed folks? I'm not at all sure that going to the county level wage data, including hospital data, tells you very much about what it costs to get a doc or a nurse to a small metropolitan area. I think it's tricky twice, not just once.

DR. NEWHOUSE: I think the docs are different, but they're not part of this.

MR. SMITH: You're right, but many of the other technical staff and nurses are, and they make up a big chunk of the hospital's wage base, right?

DR. NEWHOUSE: The wages due differ. The rationale for arguing about the national was that, let's take the extreme, you bought supplies like a bed, you bought that at national market.

It didn't matter whether you were in Dubuque or New York City. But the wage you had to pay was different in Dubuque than New York City.

MR. SMITH: But that will vary by the occupation for which you're paying the wage. In some cases you will be more affected by an adjacent or the most proximate MSAs than in others.

DR. NEWHOUSE: In principle and empirically -- you can empirically find out to what degree what you just said is true and I accept it as true. You could measure how much it is. Offsetting that I would say is then the behavioral consequences of converting to quasi-cost reimbursement.

MR. SMITH: That's right.

DR. WAKEFIELD: David, you had mentioned that this isn't imminent, but do you have any sense about how this -- the timing of the application of these new definitions -- a tricky way to get us to stop talking about rural, I might add or using that term. They didn't really have to go through all of this hassle to get some of us to stop talking about rural. I can also say non-core based statistical areas over and over and over, so look forward to that, Bob.

MR. FEEZOR: It just takes longer.

[Laughter.]

DR. WAKEFIELD: I'll get back to my question for David. David, do you have any idea about how these new definitions might come into play related to the work that CMS is doing around occupational mix related to the new labor related share that's being discussed in the Medicare bills? In other words, how is it likely -- what's the timing that all of these different, fairly significant, potential changes are going to be occurring or applied at roughly the same time, and how are we going to know what the impact of this collective, of these three pretty significant changes is going to be on the wage index?

MR. GLASS: Jack, when is the occupational mix data starting to be collected?

MR. ASHBY: We're at least a year away from, a year or more away from having occupational mix data.

MR. PETTENGILL: They say that they're supposed to have it for 2005. That is next yes. Next spring they will be issuing a proposed rule which they believe will make use of the occupational mix data.

MR. ASHBY: But the point I was going to make is that the one thing that will go ahead is the change in the MSA definition. That's on its own track and it's going forward. But it remains to be seen whether CMS will want to do whatever it is they're going to do with the micropolitans on the same schedule as they try to do the occupational mix change.

DR. WAKEFIELD: And the labor related share will likely hit relatively soon too, depending on passage of legislation.

MR. ASHBY: Pending legislative issues, yes, that appears to be on its own track as well.

DR. WAKEFIELD: So teasing out the effect of these three different policy changes is not insignificant.

MR. PETTENGILL: But, Mary, the labor share, if they do it, is an across-the-board thing. It will affect all -- if the

legislation were enacted as it stands now, it would affect rural hospitals and small urban because the labor share would be reduced to 0.62. It would not be changed for the hospitals in large urban areas. It would stay at 0.71. So you're talking about across-the-board effects. Other than the big break in the distribution between rural and other urban compared to large urban, there's no effect. Whereas, the occupational mix stuff and the labor market definitions can both change the distribution in very subtle ways all over the place.

MR. FEEZOR: Jack, help me a little bit, now that I've switched my perspective a little bit. How do you deal with measuring entrance and exit into the market in those states, or how do you take into account those states that still have certificate of need requirements?

MR. ASHBY: Entry and exits, you're talking about in the context of the specialty -- oh, on the update. Actually, the short answer to that, which probably is not a very satisfying one, is that we really were not looking at it geographically. We were trying to look at whether in the aggregate there's enough of a change do deduce that much has happened here. So we haven't really gotten down to that level.

MR. PETTENGILL: You may not have any entry or exit of new providers with a new provider number in a market where they have CON, but I've been told that in a number of markets where providers face this restriction they've found ways to change the volume of what they do and build new services into the existing providers and that sort of thing. One of the other things we look at is what's happening to the volume and the mix. So presumably you pick it up that way.

MR. FEEZOR: Second, just an observation. At least a couple of provider institutions that I've now become more familiar with have a binary charging philosophy. I don't know whether this would be helpful at all to think about, is where they in fact both are a tertiary or quantrinary care for a region, and where they also serve as a principal hospital for a county or a local market, they have two very distinct pricing with respect to their margins. One trying to in fact fulfill the public hospital role in keeping certain services fairly low, and then those that they think they have greater opportunity because they are more exclusive. So for whatever it's worth, you may hit some of that.

MR. ASHBY: That's part of the dynamics.

DR. ROWE: A couple of my thoughts have already been raised but just a couple of others. On page four, Julian, of your presentation you had a list of the factors influencing the growth of specialty providers. I'd like to think about adding one and subtracting one.

One of the pull factors, I think, is a market perception-based factor. That is, if you look at the ads for these places what they say is, this is what we do. It's the only thing we do. There is this kind of marketing prospective, if you got a heart problem, you want to go to a place where every time the anesthesiologist anesthetizes somebody it's a cardiac operation. Every patient the nurse sees is a heart patient. It's this concept of quality or focus. That may be one of the -- to

whatever extent that's attractive in the marketplace, that is one of the pull factors.

One of the push factors that you have is charity care. It suggests that these places don't do charity care. To whatever extent they are not community resources like general hospitals might be considered to be general community resources, I guess that's true. But I don't see any a priori reason why some of these institutions wouldn't give charity care. If someone is uninsured or underinsured, shows up in the emergency room of a cardiac hospital with chest pain, they're likely to get treated I would think, particularly in some states they would have to get treated.

MR. MULLER: They probably don't have an ER though.

DR. ROWE: The cardiac ones have ERs. In fact a large portion of the patients are admitted through the ERs.

DR. REISCHAUER: That's true in general, but is that true in the specialty hospitals?

DR. ROWE: I think so. I think Memorial Sloan-Kettering has an ER. These cancer patients with no platelets and they start bleeding, or they get infected and they show up acutely ill -- I think so. I'm not sure. But it's worth asking, right?

MR. PETTENGILL: But they're funny animals in the sense that -- I was driving to work today and on the radio I heard an advertisement for a cardiac hospital. But it wasn't really a cardiac hospital. It was a cardiac program at a local hospital here. It's a non-profit hospital. They've built their own big cardiac unit and they advertise it the same way that a specialty provider would.

DR. ROWE: Sure. And they have what used to be pavilions in hospitals. This is a little bit like the grocery stores to supermarket. Every hospital is a medical center. What used to be a pavilion is now a hospital. So it's such-and-such hospital at the New York Presbyterian Hospital.

MR. MULLER: What they're looking at is the freestanding ones, not the ones where somebody relabels their wing.

DR. ROWE: That's what they should be.

Just a couple of points around this. They're funny also inasmuch as there's two different categories here. Unfortunately, I don't think the N is going to be large enough to really study it as two different categories. But there is a group of these -- when you're looking at the cost, I think there's a group of these that are very research intensive. Some of these cancer hospitals are extraordinarily research intensive with tremendous NIH grant support and endowments and world-class research, et cetera. And some of these are purely for-profit, no education and research, high volume, clinical operations. I'm not saying that's not good quality, but when you look at the cost and the accounting and you're trying to compare, they may be so different that it's going to be hard to do that. You might think about a sub-categorization of an academic specialty hospital versus a non-academic specialty hospital.

The last point is with respect to how to measure the quality. I thought your points were good about the concerns about how to do this. I think it would be worth looking at the

New York State results because for cardiac procedures New York State has this well-developed program that I think Dave Axelrod started then Mark Chassen developed, and Ken Shine was the chairman of the cardiac advisory committee; very high top brass type people. There are a couple cardiac hospitals in New York like St. Francis in Long Island which I think is a big, very successful one. So there is some public record that has measured the morbidity and the mortality for cardiac programs in big general hospitals, academic and otherwise, and community hospitals, and the specialty hospitals, and that's a public record. It would be kind of interesting to look at that. That may guide you a little bit as to what comparisons are valid and which ones aren't. There may be other states that do that too. I'm just familiar with New York.

MR. MULLER: I have a question on the workplan that I've raised several times, and that is the way that we're looking at the whole question of cost reporting and the unallowed costs and so forth. Is that going to be a part of our workplan this year or any year?

MR. ASHBY: We had not --

MR. MULLER: I've raised that like three years in a row now, so I do think it can make a difference of 3, 4 percent, at least according to a number that Jack probably mentioned off the top of his head a few years ago and I keep repeating back to him. But I think if we're looking at a world of 3, 4 percent margins, if there's 3, 4 percent costs that aren't allowed we may want to at some point look at those more fully. Since it's the beginning of the year, if there's any way of working that into the workplan and taking some look at that I'd urge us to do so. So that's one point.

Then I have a question about the markups and the charges and so forth. That confused me a little bit. I understand with the attention in the last year or so, I think largely triggered by what happened -- what Tenet was doing on big charge increases that led to outlier payments and so forth, but I didn't understand that if-- this is on page seven of the Jack, Julian piece. If there is markups in DRGs -- it says, if hospitals mark up certain DRGs, one DRG more than others, this raises the payment rate. I didn't quite understand that because -- could you just elaborate on that?

MR. ASHBY: Yes. The relative weights for the DRGs, which is not the rates themselves but just how they relate to each other, are set using national charge data, and those charges are not even reduced the cost. It's just the charges. So after you standardize your charges for differences in geographic location and the like, it's then as simple as summing up the average charge per case in this DRG versus the average charge per case in that DRG and that establishes the relatives.

MR. MULLER: So if hospitals tend to do cardiac more than cancer, that would --

MR. ASHBY: Exactly. But it does have to be pervasive across all hospitals in order to --

MR. MULLER: But a single hospital is not advantaged except as regard to pattern changes of DRG weights.

MR. ASHBY: Right.

MR. MULLER: So in some sense, if hospitals get a sense that there's DRGs that could be more attractive -- it really has to be --

MR. ASHBY: I think the way to put it is that if hospitals traditionally have seen these areas as -- they want them to be more attractive, they want them to be profit centers, then if hospitals across the country that are involved in cardiac services have set higher markups for the various service units that go into cardiology, then indeed you're going to see a higher markup on cardiology DRGs across the land.

MR. MULLER: So that would take effect roughly a year later when it's recalibrated, or two years?

MR. ASHBY: Two years.

MR. MULLER: Then third, on the outpatient with 2001 being the first full year in which we really had the APC system could you comment a little bit on -- we often have long discussions about data quality but could you just elaborate a little bit more on issues of the data quality using that as the new base year, finally having full data? My sense is we had, in between the corridor payments and the hold harmless payments and so forth, does that affect at all our understanding of what the payments were for those for the years? I mean when we go to the true APC payments as opposed to having them -- not compromised but added onto by hold harmless payments and corridor payments and so forth? I don't know if my question was clear.

DR. WORZALA: I guess there are two ways that we're using this data in the system. The first would be when they actually calculate the payment rates and the relative weights for the APCs, none of the transitional corridor or TOPS payments are included. That is just looking at the charges for the services reduced to cost. Then when we do our analysis of payment adequacy, however, and go to the cost reports, the cost reports do include a line for the hold harmless and other TOPS payments, transitional corridors, so it will come in there.

But in terms of the data quality, I thought you were actually going to get to the point of hospital coding and how much coding has had to change from implementation of the system. I do think that each year the data used for setting the payment rates is improving a little bit, and CMS continues to refine their methodologies and there are still some hiccups in the process.

MR. DURENBERGER: My question or comment is -- it's a combination I guess -- for Julian on pages four and five, which is the factors page and the research page. On the factors side -- and I may be capturing some of the existing factors, but if I look at the community that Minnesota is the center of in the upper Midwest, I think we're the only state in the country that forbids for-profit hospitals and things like that. But despite that, if I had to add something to the pull factors it would be the competition.

It would be competition in some cases -- usually this is at the community level, but sometimes it's market to market. It's so prevalent that it dominates all of, especially the capital

decisions that are being made that relates to what specialty providers are able to do. But it can be hospital to hospital where hospitals are driving the market for health care or medical services. It can be clinic to clinic. It can be when you get down to the micro MSA level, it's probably clinic versus the specialty. Then in many areas it's market to market where there is a prevalent, let's say a Mayo Clinic with a prevalent tertiary, quatrary, whatever it is, presence and there's a defense in a market in South Dakora and another defense in a market in Wisconsin or something like that. For marketing and other kinds of reasons, but probably mostly to secure the subspecialty professional services that are needed, this competition is influenced heavily by the ability of a group of subspecialists to create their own enterprise versus the hospital having to compete with them by building or investing in the competitor.

I'm not sure the degree to which that is a research or an analytical factor, but I know it is so prevalent in this community despite the fact that there are some other relative profitabilities, and their production environment and things like that, the real driving force at the decision-making level where you're investing lots of money one way or the other is in that -- I'll just call it competition.

Now related to that is this very interesting research question on efficiency and quality of care. Because I happen to think efficiency is absent from medical care delivery, it's interesting to me that you'd like to incorporate it into the equation.

The people at 3M who do six Sigma and things like that rank, the only thing in medicine they rank anywhere near six Sigma is anesthesiology at five and they put all the rest of the system at about 2.5 or something like that. So if that's the case, and if trying to determine if it's more efficient to set up a freestanding versus something else, or just if you're looking at what is the real cost of delivering a service, it strikes me that whether it's appropriate for this project or it's appropriate somewhere else, what capacity we have to really dig into the efficiency of each of these hospital-like delivery systems would be very, very important.

My anecdotal experience was going to one big hospital to get an x-ray and the guy who I met over there said, we just paid $22 million to attract a radiologist, to build up our radiology department. After I'd been sitting there for 30 minutes or something like that I said, why does this take so long? He said, because we're getting very close to 3:30 in the afternoon and everybody goes home at 3:30 in the afternoon. I said, suppose I wasn't who I am and I could get in like that? Well, you usually have to wait about a week at this facility.

Now I know in my community there's a guy who's built a national and international radiological business because he considers the patient and the doctor his customers. If somebody calls at 3:00 in the afternoon and wants to be seen at 4:00, they get seen. And the doctor on the other side of the country or the other side of town gets to read the results almost

instantaneously.

To the extent that that little anecdote, to me is a huge example of efficiency, or inefficiency in the first case, over time, I don't know whether the capacity in this project, or where it is, to examine that exists, but it feels like it's a very important part of trying to come to some conclusions about what is the role of the payment system.

MR. PETTENGILL: I guess I would be the first one to admit that our capacity to measure both risk and quality of outcome is extremely limited, and without them we're not going to be able to say a whole lot about who's more efficient or less efficient. We can say who has higher or lower costs, but we can't really tell whether that's more or less efficient. That's the world in which we live at the moment.

MR. DURENBERGER: That's what you said before, but I think I'm asking a different question, which is just examining the underlying efficiency, not just did you both get the same result. Is this what you're saying, if you both got the same result, how much did it cost you to et it versus --

MR. PETTENGILL: Controlling for risk, yes. Maybe we should have a more extensive conversation about that sometime, because I think what you're referring to is using a different set of --

DR. REISCHAUER: He closes down at 3:30.

[Laughter.]

MR. HACKBARTH: Unfortunately, we are well over time right now. It's past 3:30 right now.

MR. SMITH: As with Ralph, I want to raise an old hobby horse. It would seem to me that the Medicare margin is even less useful to us in many of the specialty hospital situations than it may be in the general hospital. We've got to look at the entire book of business and try to understand what we can about the contribution of Medicare to that. But I think looking at the Medicare margin in an orthopedic hospital is unlikely to tell us what we want to know about the effect of that new orthopedic hospital on the general hospital across the street. So I think we've got to reraise those questions.

David, just very quickly, my guess is that whatever is going to happen is going to be so stop-and-go that looking at the longer-term issues, trying to make some sense out the deeper labor market questions that you raise is a much more useful investment of your time and your colleagues' time than trying to parse out what's going to happen to these 620 hospitals that used to be in the balance of state and are now all of a sudden in some new unit that nobody understands quite what it is.

MR. HACKBARTH: Thank you.